

Registered pharmacy inspection report

Pharmacy Name: Pascoe Pharmacy, 235-237 Knights Hill, West Norwood, LONDON, SE27 0QT

Pharmacy reference: 1040962

Type of pharmacy: Community

Date of inspection: 20/10/2021

Pharmacy context

This pharmacy is located within a parade of shops in a residential area. The pharmacy provides the Covid-19 vaccination Service. It also provides medication in multi-compartment compliance packs to people who live care homes and those in their own homes and need help managing their medicines. The inspection took place during the Covid-19 pandemic.

Overall inspection outcome

✓ **Standards met**

Required Action: None

Follow this link to [find out what the inspections possible outcomes mean](#)

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy adequately manages the risks associated with its services. People who use the pharmacy can provide feedback and the pharmacy team have received training to help protect the welfare of vulnerable people. When a dispensing mistake occurs, team members generally react appropriately. But they do not always review dispensing mistakes. So, they might be missing opportunities to learn and make the services safer.

Inspector's evidence

The pharmacy had made a number of changes as a result of the Covid-19 pandemic. A staff risk assessment had been completed early in the pandemic. Signage was displayed to help remind people of the restrictions and plastic screens had been fitted at the front counter and in between chairs in the waiting area. Personal protective equipment (PPE) and hand sanitisers were available for the team and members of the public.

Standard operating procedures (SOPs) were available at the pharmacy. All current members of the team had signed the relevant procedures to confirm that they had read and understood them. The SOPs had been reviewed late 2020 and were due to be reviewed again in 2022. Responsibilities of team members were listed on individual SOPs.

The superintendent pharmacist (SI) said that dispensing mistakes which were identified before the medicine was handed to a person (near misses) were documented electronically, but he could not access previous records during the inspection. Near misses were discussed with the member of the team involved as well as the wider team but they were not routinely reviewed. Some changes had been made to reduce the likelihood of the mistake, for example, carbamazepine and carbocisteine solutions had been separated on the shelves as they had similar packaging.

Dispensing mistakes which reached people (dispensing errors) were also recorded electronically and reported on the National Reporting and Learning System. There had not been any dispensing errors at the pharmacy for some time.

The pharmacy had current indemnity insurance cover. The correct responsible pharmacist (RP) notice was displayed. Samples of the RP record were seen to be well maintained. Other records required for the safe provision of pharmacy services were generally completed in line with legal requirements, including those for private prescriptions and unlicensed medicines. Emergency supply records did not always include the nature of the emergency. This may mean that the pharmacy is not be able to provide evidence of how the decision to make a supply in the absence of a prescription was reached. A sample of controlled drug (CD) registers was inspected, and these were filled in correctly. CD balance checks were checked at regular intervals. The physical stock of a CD was checked and matched the recorded balance.

People were able to give feedback or raise concerns online or verbally. The pharmacy's complaints procedure was displayed in the retail area.

Members of the team had completed information governance training and had signed confidentiality

agreements. Confidential waste was collected by an approved waste contractor, computers were password protected and smartcards were used to access the pharmacy's electronic records. Cordless telephones were available so that members of team could have private conversations away from people. The consultation room was fitted with a Digi-lock to keep patient-sensitive information secure when the room was not in use.

Most members of the team had completed the Centre for Pharmacy Postgraduate Education training on Safeguarding children and vulnerable adults as well as refresher training. They said they would find the contact details of local safeguarding teams online.

Principle 2 - Staffing ✓ Standards met

Summary findings

Team members work well together, and they manage the pharmacy's workload well. They feel comfortable about raising concerns. They complete ongoing training to keep their skills up to date. But they do not always start the relevant accredited training courses in a timely manner.

Inspector's evidence

During the inspection there was the SI, a locum pharmacist, a trainee pharmacist, a dispenser and an assistant. The assistant had been working at the pharmacy six months ago but was yet to be enrolled onto a suitable course. She was involved in selling over the counter (OTC) medicines, date checking dispensary stock and picking stock for prescriptions. Following the inspection, the SI sent evidence confirming the assistant's enrolment onto a healthcare assistant course.

The assistant said that she asked several questions before referring to the pharmacist when selling OTC medicines. She did not sell any medicines without first checking with the pharmacist. She was aware of higher-risk medicines and described how she would deal with multiple requests for these.

The dispenser said he kept his knowledge and skills up to date by reading the BNF, patient information leaflets and pharmacy magazines. He also worked one day a week at another pharmacy, which was part of a large multiple. He completed training there and said he shared learnings with this team. He described learning from near misses and dispensing mistakes and signposting people to services which may benefit them, such as the multi-compartment compliance pack service. He added that the SI had recently discussed enrolling him onto the Level 3 technician training course.

The trainee pharmacist said she had spent one day reading the SOPs and learning about processes at the start of her training. She was provided with a checklist of tasks to complete during her induction week, such as advising people and dispensing a prescription. She was signed onto a trainee pharmacist course with a training provider and completed regular assessments with them. She also worked at a GP practice two days a week and said that this helped improve the continuity of services for people accessing the pharmacy, for example, she was able to follow up any queries whilst at the GP practice. She added that the SI regularly gave her feedback about her performance.

Team members reported that the SI was open to feedback and they felt comfortable to approach him with any issues regarding service provision. Performance was discussed every six months. Targets were not set for team members.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are suitable for the services offered and they are kept secure. There is a room where people can have private conversations with a team member.

Inspector's evidence

The pharmacy was clean and maintained to a level of hygiene suitable for the provision of its services. There was a separate room behind the dispensary which was used to prepare vaccines and store some stock. The room was fitted with workbenches and shelves and was kept clean and tidy. Dispensary workbenches were slightly cluttered and were being used to assemble multi-compartment compliance packs. The team members said they would review this to help ensure that packs were assembled in an area with limited distractions, to help reduce the likelihood of errors. Some stock was stored in a disorganised manner on the shelves. The team members said they would rearrange these.

General cleaning was done by members of the team. Chairs, pens and surfaces were disinfected after every person. The ambient temperature and lighting were suitable for the services provided.

The retail area had been split using retractable barrier tape to create an area for the Covid-19 vaccine service. There were several wipeable chairs, some with plastic screens in between and others kept at a safe distance from each other. This section was used as a waiting and observation area. One pod was used to administer the vaccines and this was fitted with a curtain for privacy.

A signposted consultation room was available for private conversations or other services. The room was easily accessible and generally clean and tidy. A small kitchenette and toilet were available for the pharmacy team. The premises were secure from unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

People can access the pharmacy's services. The pharmacy has some systems in place for making sure that its services are organised. And it orders its medicines from reputable sources and largely stores them properly. The pharmacy sometimes assembles multicompartiment compliance packs without checking against the prescription. And this may increase the likelihood of mistakes being made.

Inspector's evidence

There was step-free access into the pharmacy and sufficient space in the retail area for people with wheelchairs or pushchairs. Services were listed on the window and on the pharmacy's website.

There was sufficient workspace and baskets were used to separate prescriptions and prevent transfer between people. Dispensing audit trails to identify who dispensed and checked medicines were completed. This helped identify who was involved in these processes, for example, if a dispensing mistake occurred.

The dispenser and trainee pharmacist were aware of the checks and labelling requirements of dispensing sodium valproate to people in the at-risk group, but information leaflets and cards were not available. The dispenser said that he would order additional supplies. The dispenser said that the pharmacy checked if people taking other higher-risk medicines were being routinely monitored though records of any checks were not maintained.

Multi-compartment compliance packs were assembled in the dispensary, on relatively cluttered work benches. The team said they would review the work and storage arrangements in the dispensary to create a designated area for this service. Packs were at times assembled against backing sheets rather than prescriptions. The risks of this practice were discussed with the team who said they would review the process. Prepared packs observed were labelled with product descriptions and mandatory warnings.

Covid-19 vaccines were prepared in a separate room which was fitted with work benches and a fridge used solely to store the vaccines. Diluted vaccines were stored inside small tubs and surrounded with sponge to help minimise movement which could impact the stability of the vaccine. The vaccine preparation area was kept clean and tidy. Vaccines were mixed by the SI or locum pharmacist and administered by a nurse. The vaccine checking-in desk was manned by an assistant who also helped in the dispensary during quieter periods. Post-vaccination observations were carried out either by the SI or the injector, however, they were not always directly observing people. This was discussed and the SI said he would review staffing arrangements and ensure that the observer was not carrying out other tasks.

The pharmacy provided medication in original packs to residents of three nursing homes. Prescriptions were managed by the care home staff and copies of the requests were sent to the pharmacy for reference. Medicines were at times dispensed against backing sheets rather than prescriptions. The risks of this practice were discussed with the SI who said the service would be reviewed.

Amber medicine bottles were seen to be reused for people receiving substance misuse treatment. The pharmacy team were advised against reusing bottles for hygiene purposes. The SI said that this practice would stop and a new bottle would be used for each instalment.

Medicines were obtained from licensed wholesalers and generally stored appropriately. Members of the team said that stock was date checked regularly but date-checking records were not clear as it was not possible to identify when the checks had been made. No expired medicines were found on the shelves in a random check in the dispensary.

Uncollected medicines were removed from the shelves every three months to help reduce clutter. Prescriptions were retained in a folder should the person return to collect their medicine later. There was no system in place to highlight Schedule 3 and 4 CDs once they were dispensed. This could increase the likelihood of supplying these medicines past the valid date on the prescription.

The pharmacy had three fridges. One was used to store dispensary stock, another was used to store vaccines and the third was not in use. The temperatures of the fridge used for dispensary stock had not been recorded for two to three weeks. The dispenser said that the temperatures were normally checked but may not have been documented. He added that these would be recorded in the future to help keep track of the temperatures. The fridge temperature was seen to be within the recommended range at the time of inspection. The temperatures for the fridge used to store vaccines were checked and recorded daily. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier. Drug alerts and recalls were received from the MHRA, actioned, and filed for reference.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely

Inspector's evidence

The pharmacy had several glass measures and tablet counting triangles, including a separate triangle for cytotoxic medicines. This helped avoid cross-contamination. There were two fridges, one was used to store dispensary stock and another for vaccines. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several up-to-date reference sources.

What do the summary findings for each principle mean?

Finding	Meaning
✓ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✓ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✓ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.